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From Twilight to Breaking Dawn? Best Interests, Autonomy and Minimally Conscious Patients

Richard Huxtable

M v N [2015] EWCOP 76 (Fam)

1. INTRODUCTION

In law, as in the alphabet, N comes after M. Like M, whose case was decided in 2012,¹ N was in a minimally conscious state (MCS), a disorder of consciousness in which the patient nevertheless exhibits some sign of consciousness.² The issue in N's case, as in M's, was whether or not clinically assisted nutrition and hydration (CANH) should continue to be provided. The MCS is distinguishable from the permanent vegetative state (PVS), in which sleep-wake cycles are observable but the patient appears unaware, uncommunicative and incapable of purposeful behaviour.³ Yet, if the patient occupies either of these 'twilight world[s]',⁴ the court must decide whether or not CANH can be withdrawn.⁵ In M's case, this treatment stayed in place; in N's case, Hayden J decided that the treatment could cease. Critics of Baker J's ruling in M's case had charged him with over-emphasising the intrinsic value of life.⁶ Those critics might welcome Hayden J's decision, with its orientation towards respect for the patient's autonomy. We might wonder, however, whether this is not a new dawn, but rather a false dawn, in healthcare law.

2. THE CASE

A. The Factual Background

68-year-old N was receiving CANH through a percutaneous endoscopic gastrostomy (PEG) tube. Whilst mindful of the need to respect N's privacy and dignity, Hayden J felt it appropriate to set out the 'broad canvass of evidence which inform my ultimate decision'.⁷ Hayden J commended the candour of N's family, from whose evidence N emerged as someone who 'could at times be capricious, selfish and seemingly shallow' and was "'proud", jealous of her privacy, extraordinarily "feisty" ... and profoundly loyal to her children'.⁸ N had been diagnosed with multiple sclerosis 23 years previously, following a fall in 1991. From the outset, N resisted the diagnosis, the effects of the condition (for example, on her speech, mobility and memory) and the aids she required (such as a Zimmer frame then wheelchair). Her mood would change rapidly, and she was often resentful and aggressive towards her carers and family.

¹ *W v M and S and A NHS Primary Care Trust* [2011] EWHC 2443.

² Royal College of Physicians, *Prolonged disorders of consciousness: National clinical guidelines* 2013 (London: Royal College of Physicians).

³ *Ibid.*

⁴ *NHS Trust v I* [2003] EWHC 2243, *per* Butler-Sloss P, [8].

⁵ COP (Court of Protection) Practice Direction 9E, [5].

⁶ *E.g.* A Mullock, 'Deciding the Fate of a Minimally Conscious Patient: An Unsatisfactory Balancing Act?' (2012) 20(3) *Med LR* 460; E Jackson, 'The minimally conscious state and treatment withdrawal: *W v M*' (2013) 29 *J Med Ethics* 559; R Huxtable, "'In a Twilight World": Judging the Value of Life for the Minimally Conscious Patient' (2013) 39 *J Med Ethics* 565.

⁷ *M v N* [2015] EWCOP 76 (Fam) [3]. References are to this judgment unless otherwise stated.

⁸ [50].

By 2006, N was severely cognitively impaired, unable to communicate normally, doubly incontinent, epileptic, and had increased spasticity to her limbs and difficulty swallowing. Although her family had long sought to preserve N's independence, by 2007 she was living in a care home, where PEG feeding was instituted a year later. N's inexorable deterioration continued and by 2010 she was quadriplegic and endured pressure sores and frequent chest infections. Around this time, N's daughter expressed concerns about her mother's quality of life. N's condition continued to worsen thereafter. In 2015, discussions occurred about replacing N's PEG tube, which was still functioning efficiently, albeit far beyond 'its anticipated life'.⁹ This appeared to prompt N's family to conclude that N's situation 'was intolerable and she no longer remained alive in any sentient sense'.¹⁰ With the Official Solicitor appointed to act as litigation friend, the family approached the court to determine, in the judge's words (and with his emphasis), 'Whether it is in Mrs N's best interests *to continue* to receive the medical treatment which is presently administered to keep her alive, namely artificial nutrition and hydration by way of the PEG tube'.¹¹

B. The Decision

Hayden J began by rehearsing the guidelines informing the diagnoses of PVS and MCS.¹² As the guidelines note, families and other visitors can inform a diagnosis, although Hayden J recognised that their observations can sometimes be mistaken.¹³ Assessment tools are needed to determine the correct diagnosis: of the 13 available such tools, he noted that the Court of Protection most commonly encountered the JFK Coma Recovery Scale – Revised (CFS-R), the Wessex Head Injury Matrix (WHIM) and the Sensory Modality Assessment and Rehabilitation Technique (SMART).¹⁴ In M's case – which, said Hayden J, appeared to be the only previous case in which withdrawal of CANH was considered from a patient in a MCS¹⁵ – Baker J had thought their use 'crucial'.¹⁶ Hayden J doubted that his predecessor had meant that such tools would be 'determinative of the outcome of cases of this kind'.¹⁷

Hayden J next outlined the pertinent provisions of the Mental Capacity Act 2005. N lacked capacity (and, indeed, a valid and applicable advance decision to refuse treatment), so the decision was to be made in her best interests, in accordance with s. 4. Such interests are to be considered 'in the widest sense';¹⁸ the assessment has objective dimensions but also 'a strong element of substituted judgment'.¹⁹ For Hayden J, this indicated 'the importance of giving proper weight to P's wishes, feelings, beliefs and values', where these might be gleaned verbally or non-verbally.²⁰ The Code of Practice accompanying the 2005 Act bore out 'the importance of personal autonomy' and the need to avoid 'a paternalistic approach'.²¹ The Act's support for a (properly executed) advance decision to refuse treatment further reinforced the

⁹ [12].

¹⁰ [12].

¹¹ [13].

¹² *Op cit*, n 2.

¹³ [22].

¹⁴ [21].

¹⁵ [24].

¹⁶ [23].

¹⁷ [23].

¹⁸ *Aintree University Hospitals NHS Foundation Trust v James and others* [2013] UKSC 67, *per* Baroness Hale, [39].

¹⁹ [27], citing *Aintree* (*op cit*, n 18), *per* Baroness Hale, [24].

²⁰ [28].

²¹ [30].

point that ‘the presumption of life, predicated on what is often referred to as the “sanctity of life” of the “intrinsic value of life”, can be rebutted’.²²

Hayden J then turned to N’s present condition, about which there was a dispute between the three medical witnesses about the nomenclature to be applied. They all agreed with the SMART test’s finding that N’s level of awareness was low. They also accepted that N was able to “fix” and “track” objects within her line of vision’.²³ Despite preferring to reserve the MCS label for those enduring the sudden onset of severe brain injury, rather than a progressive decline,²⁴ two of the experts felt this was the correct diagnosis. Contrary to the guidance, the third felt that visual tracking was not incompatible with a PVS diagnosis,²⁵ which was how he chose to characterise N’s condition.

Hayden J concluded that ‘the reality of the disagreement is far narrower clinically than is the theoretical divide’,²⁶ although he appreciated the legal significance thereof. If N was in a MCS, then a (‘qualitative rather than merely numerical’²⁷) balancing exercise was required, in which a ‘balance sheet’ was to be constructed, comprising factors for or against taking a particular course in the patient’s best interests. If N was in a PVS, then no such exercise was required, as the ‘futility of the treatment’ justified its termination, as Sir Mark Potter has put it.²⁸ Hayden J noted that the court could not arbitrate on issues of medical disagreement – unless adjudication required this.²⁹ Here, he sided with the majority of the expert witnesses: N’s limited cognitive functioning seemed ‘inconsistent with the general premise of a vegetative state’.³⁰ A full analysis of N’s best interests was therefore warranted.

Hayden J felt that ‘a formulaic “balance sheet” approach’ would be ‘artificial’.³¹ Delving into N’s best interests, Hayden J recounted the difficulties she had encountered in her earlier life,³² and remarked on her ‘indomitable spirit’³³ and ‘occasional profligacy’.³⁴ A visit to her demented and ‘diminished’ parents, when they were residing in a care home, had prompted N to tell her daughter: ‘if I ever get like that shoot me!’³⁵ Her ex-husband had heard similar remarks, as well as N’s wish that ‘she did not want to be a burden’.³⁶ Soon after her own diagnosis, which she had resisted so deeply, N had ‘railed in intemperate language to her son that she wanted to die’.³⁷ The family considered such comments to reflect clearly what N would now want. After further referring to N’s pride (and, indeed, her inabilities as a cook), Hayden J felt he had ‘part of a picture which helps me to understand Mrs N’s moral imperatives and the code by which lived her life’.³⁸

Before finally addressing the case law, Hayden J explained that he had sought evidence from the three expert witnesses, in addition to the evidence provided by the SMART test, because

²² [32].

²³ [36].

²⁴ [34].

²⁵ E.g. MA Bruno, A Vanhaudenhuyse, C Schnakers, M Boly, O Gosseries, A Demertzi, S Magerus, G Moonen, R Hustinx, S Laureys, ‘Visual fixation in the vegetative state: an observational case series PET study’ (2010) 10 *BMC Neurology* 35, cited by Hayden J at [41].

²⁶ [43].

²⁷ [46].

²⁸ *A Hospital v SW* [2007] Med LR 273, [28].

²⁹ [48].

³⁰ [49].

³¹ [70].

³² [51].

³³ [52].

³⁴ [53].

³⁵ [55].

³⁶ [56].

³⁷ [57].

³⁸ [59].

of his discomfort with the fact that the application was ultimately unopposed. The Official Solicitor had changed his mind on hearing the family's evidence in court. The most pertinent case law, meanwhile, was said to be *Bland*,³⁹ M's case and *Aintree*.⁴⁰ M's case suggested that life with disability can be positive. *Bland* (particularly the decision of Hoffmann LJ) conveyed the importance of the court's decision conforming to the convictions of ordinary people, as well as the possibility that the intrinsic value of life could be outweighed by considerations of autonomy and dignity.⁴¹ *Aintree* then emphasised the importance of framing the court's decision appropriately: as Hayden J summarised, 'the question was properly formulated not as the "withholding of treatment" but focused instead on the patient's best interest'.⁴² The declaration was granted: in Hayden J's words, 'respect for Mrs N's dignity and human freedom overwhelms further prolongation of life'.⁴³ He was satisfied that N's views were accurately conveyed by her family in evidence and these, along with 'the intrusive nature of the treatment and its minimal potential to achieve any medical objective, rebut any presumption of continuing to promote life'.⁴⁴

3. DISCUSSION

A. Twilight

As Hayden J outlines, if the patient is in a PVS, then withdrawal of CANH is apparently a certainty; if she or he is in a MCS, then the outcome turns on an assessment of their best interests. His ruling not only emphasises the importance of appropriately ascertaining which 'twilight world' the patient inhabits, but also reminds us of the power of labels and language. In the two decades since *Bland*, the courts have become familiar with determining the fates of patients in a PVS.⁴⁵ Withdrawal of CANH is not a foregone conclusion,⁴⁶ but this is usually the outcome. Some have called for the suspension of the requirement to bring such cases to court.⁴⁷ Whether or not such calls are heeded, if non-treatment is to be the routine outcome for PVS patients, confirmation is needed that the patient is indeed in a PVS. Yet, the courts have encountered some near misses⁴⁸ and have also, on occasion, endorsed the withdrawal of treatment from purported PVS patients whose diagnoses were not entirely settled.⁴⁹ Publication of the MCS label and diagnostic criteria, in 2002, post-dated these cases.⁵⁰ It is nevertheless possible that at least some of these were cases in which MCS, rather than PVS, was the

³⁹ *Airedale NHS Trust v Bland* [1993] AC 789.

⁴⁰ *Aintree* (op cit, n 18). Hayden J also reinforced his emphasis on autonomy by citing article 8 of the Human Rights Act 1998, *Pretty v United Kingdom* [2002] 35 EHRR 1 and *R (Purdy) v DPP* [2009] UKHL 45: see [76]-[78].

⁴¹ *Bland* (op cit, n 39), 826E, 829H, 830G.

⁴² [68].

⁴³ [79].

⁴⁴ [75].

⁴⁵ See R Huxtable, *Law, Ethics and Compromise at the Limits of Life: To Treat or Not to Treat?* (Routledge, Abingdon 2012), ch 3.

⁴⁶ *B NHS Trust v J* [2006] EWHC 3152. But see also *An NHS Trust v J* [2006] All E.R. (D.) 73 (Dec.).

⁴⁷ E.g. Huxtable (op cit, n 6), 567; S Halliday, A Formby and R Cookson, 'An Assessment of the Court's Role in the Withdrawal of Clinically Assisted Nutrition and Hydration from Patients in the Permanent Vegetative State' (2015) 23(4) *Med L Rev* 556; C Kitzinger and J Kitzinger, 'Court Applications for Withdrawal of Artificial Nutrition and Hydration from Patients in a Permanent Vegetative State: Family Experiences' (2016) 42(1) *J Med Ethics* 11.

⁴⁸ E.g. the case mentioned in Hinchliffe (1996: 1580), in which the alleged PVS patient was found to have capacity.

⁴⁹ E.g. *Frenchay NHS Trust v S* [1994] 1 WLR 601; *Re D (medical treatment)* [1998] 1 FLR 411; *Re H (A Patient)* [1998] 2 FLR 36; *Re G (Adult Incompetent: Withdrawal of Treatment)* (2002) 65 BMLR 6.

⁵⁰ JT Giacino, S Ashwal and N Childs, et al. 'The minimally conscious state: definition and diagnostic criteria' (2002) 58 *Neurology* 349.

appropriate diagnosis.⁵¹ If so, the courts have been addressing MCS for longer than has otherwise been assumed (including by Hayden J in N's case).

Whatever the truth, it is at least clear nowadays that MCS cases must also come to court and M's case certainly appeared to be the first to confront the condition head on. The case law is now growing. However, as it was with PVS, so it is with MCS: the recent cases again reveal doubts about diagnoses.⁵² Sometimes an initial PVS diagnosis has been overturned in favour of MCS and the court has authorised the continuation of treatment.⁵³ The outcomes would likely have been starkly different had the PVS diagnoses stood. The importance of getting the diagnosis right is readily apparent.

Also apparent in these cases is the importance of language, a theme which runs throughout Hayden J's judgment. There are words from, and about, N: according to the judge, she used 'intemperate language' when expressing her anguish at life in her condition.⁵⁴ There are the words of the expert medical witnesses, who had 'reservations about the correct terminology' to be applied to that condition.⁵⁵ And Hayden J himself acknowledges that the terms attached to some such patients are unsatisfactory:

'The terminology in this area of medicine and law is fraught with difficulty and the potential to cause distress and offence. There is something inherently dehumanising in the term "vegetative state". On the other hand, that is, in part, its intention i.e. to signal the absence of sentient life, to emphasise that a patient is both unaware and free from suffering'.⁵⁶

In recognition of its problems, some scientists have proposed that PVS be replaced with 'post-coma unresponsiveness' or 'unresponsive wakefulness syndrome'.⁵⁷ Like them, Hayden J does well to recognise the objectionable obstacles that language can present.⁵⁸ Yet, he might not have avoided them entirely.⁵⁹ Of particular note are the efforts to which Hayden J goes to articulate just what it is he is deciding.

Hayden J opens by saying that the application concerns 'a declaration determining whether it is in the best interests of Mrs N to receive life-sustaining treatment' via PEG feeding.⁶⁰ He later emphasises that the issue before the court is '[w]hether it is in Mrs N's best interests *to continue* to receive' this treatment.⁶¹ He spells out that 'this case is not concerned with a right to die',⁶² and even takes care (drawing support from Baroness Hale) to avoid the impression that the case

⁵¹ Baker J concedes this in *W v M* (op cit, n 1), [256]. See e.g. the initially split opinions in *NHS Trust A v H* [2001] 2 FLR 501.

⁵² E.g. *W v M* (op cit, n 1); *An NHS Trust v L* [2013] EWHC 4313 (Fam); *Sheffield Teaching Hospitals NHS Foundation Trust v TH* [2014] EWCOP 4.

⁵³ E.g. *W v M* (op cit, n 1); *St George's Healthcare NHS Trust v P* [2015] EWCOP 42.

⁵⁴ [57].

⁵⁵ [43].

⁵⁶ [16].

⁵⁷ National Health and Medical Research Council, *Post-coma unresponsiveness (vegetative state): A clinical framework for diagnosis: An information paper* (Canberra, NHMRC 2004); S Laureys, GG Celesia, F Cohadon, et al. 'Unresponsive wakefulness syndrome: A new name for the vegetative state or apallic syndrome' (2010) 68 *BMC Med*.

⁵⁸ We are less likely now to see a judge refer to an incapacitated patient as a 'cabbage': *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33, per Donaldson MR, 42.

⁵⁹ For example, in an echo of Donaldson MR's (also) problematic 'flak jacket' (*Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, 78), Hayden J suggests (at [42]) that the evidence of visual tracking 'should not be regarded as a strait jacket to diagnosis' of MCS. Moreover, although long-established in law, some might still contest the characterisation of CANH as 'treatment' (at [69]): see e.g. J Keown, *The Law and Ethics of Medicine: Essays on the Inviolability of Human Life* (Oxford University Press 2012).

⁶⁰ [1].

⁶¹ [13].

⁶² [70].

concerns the withdrawal of treatment.⁶³ We have been here before. The judges' discomfort with spelling out the true effect of their declarations was perhaps most starkly exemplified in *Re C*, in which the Court of Appeal felt that Ward J (as he then was) had 'failed to express himself with his usual felicity' when he gave leave 'to treat the minor to die'.⁶⁴ On the substantive issue, the court agreed with Ward J that life-support could be withheld from the child, although it removed the 'misleading phrase' from its declaration.⁶⁵

Ward J's formulation was rather on the nose and might have invited misinterpretation. But, with respect to Hayden J, the true import of a ruling like that in N's case should not be concealed.⁶⁶ In effect, the court *must* be saying that withdrawal of treatment, with the result that the patient dies, is in (or at least not contrary to) the best interests of the patient. The Code accompanying the 2005 Act, which Hayden J cites, is more honest in this regard.⁶⁷ More honest still was Hoffmann LJ, whom Hayden J also cited, who had asked in *Bland*: 'Can it ever be right to cause the death of a human being by deliberately depriving him of food?'⁶⁸ The answer implicit in the declarations made in both *Bland* and N's case must simply be 'yes'. A degree of tact is of course necessary, particularly when dealing with the families and clinicians caring for the patient. But such sensitive engagement should not enable the court – or anyone – to obscure or deny the true import of the decision.⁶⁹

B. Breaking Dawn

As opaque as the declaration might appear, in other respects Hayden J's ruling is transparent. It was certainly apparent, from the outset, in which direction the judge would rule. Commentators will doubtless welcome his decision as a fresh dawn for healthcare law, in which the light of autonomy further breaks through the perceived darkness of the sanctity of human life.

The best interests test is readily capable of accommodating these potentially competing values, its flexibility being seen as both a strength and a weakness.⁷⁰ Although philosophers cannot agree on how best to conceptualise a person's welfare, the theories tend to tether welfare to the satisfaction of one's preferences, the attainment of particular positive mental states, or the promotion of particular objective goods, such as life.⁷¹ Hayden J sees his task as weighing the third such account against the first i.e. the 'inviolability of life' against 'an individual's right to self determination or personal autonomy' (or 'the philosophical against the personal').⁷² In stark contrast to Baker J in M's case, Hayden J ultimately expresses a(n apparently⁷³) strong preference for patient preferences pointing the way forward.

⁶³ [68].

⁶⁴ *Re C (a minor)(wardship: medical treatment)* [1990] Fam 26 *per* Donaldson MR, at 35.

⁶⁵ *Ibid*.

⁶⁶ See also S Ost, 'A right to live at the end of life in the way one would wish or a right to die: Is there a difference?' *Lancaster University Law School Blog* 24 November 2015 <http://www.lancaster.ac.uk/law/blogs/staff/a-right-to-live-at-the-end-of-life-in-the-way-one-would-wish-or-a-right-to-die/> (accessed 4 February 2016).

⁶⁷ See [29].

⁶⁸ [65].

⁶⁹ The complicated questions associated with intention and motivation, which might influence the labels we wish to apply, must be left for another time.

⁷⁰ G Douglas, *An Introduction to Family Law* (Oxford University Press 2004); J Herring, 'Farewell welfare?' (2005) 27 *Journal of Social Welfare and Family Law* 159.

⁷¹ D Degrazia, 'Value theory and the best interests standard' (1995) 9 *Bioethics* 50.

⁷² [70].

⁷³ I explain why this might only be apparent in the next section.

Hayden J reaches this point after first acknowledging the need for a wide approach to assessing the patient's best interests.⁷⁴ Having resolved that N was in a MCS, a balancing exercise was required.⁷⁵ Such an exercise, he remarks, is qualitative,⁷⁶ which goes some way to explaining how Baker J had reached the opposite result in M's case. Baker J had methodically outlined numerous factors for and against withdrawing CANH but he ultimately – and crucially – declared that 'the importance of preserving life is the decisive factor in this case'.⁷⁷ Although Hayden J felt that a 'full analysis' of N's best interests was required,⁷⁸ he was not so methodical, believing a 'formulaic' approach to be 'artificial'.⁷⁹ With respect, this makes it hard to discern whether he detected more than the sanctity of life on the side of continuing N's treatment; Baker J's judgment at least had the virtue of transparency in this regard.⁸⁰ As it was, Hayden J felt the balance sheet offered only a 'route to judgment',⁸¹ and it was pretty evident which destination he was going to reach.

Whilst noting that cases will vary, such that patient preferences will not always be determinative, Hayden J strongly endorses the dominance of autonomous wishes – at least, in a suitable case.⁸² Factoring in a patient's wishes is 'a crucial part of promoting best interests. To subvert these to a substitution of an objective evaluation i.e. to superimpose what the Court thinks best, may result in indirect discrimination'.⁸³ Life can be trumped by choice, he says, not only where the patient has capacity, but also 'by parity of analysis', where the patient is incapacitated, yet their wishes have been 'communicated to the court via family or friends but with similar cogency and authenticity'.⁸⁴ Hayden J thus uses the evidence provided by N's loved ones to construct a narrative of N's 'moral imperatives and the code by which she lived her life'.⁸⁵ One might query whether the judgment needed quite such a 'broad canvass',⁸⁶ but the details of N's life help to create a picture of who *she* was and what *her* preferences were and would be (Hayden J notably emphasises 'she' and 'her').⁸⁷ Through such efforts, we are gifted what Coggon would describe as an account of N's 'best desire autonomy', on which basis N would oppose the continued provision of CANH.⁸⁸

Hayden J draws further sustenance from Hoffmann LJ in *Bland*. It is notable that he looks to the Court of Appeal, rather than the Lords' opinions in that case: perhaps the Lords might not have served his purpose? Yet, it is not entirely clear that Hoffmann LJ does so, either. Hayden J cites Hoffmann LJ's views on the importance of not only autonomy, but also dignity. Hoffmann LJ seems to see the concepts as distinct, with dignity effectively depicted as an

⁷⁴ Despite mentioning the perceived 'intolerability' of N's life, he implicitly heeds the Court of Appeal's warning that such a notion is not to be used as a gloss on best interests: *Wyatt v Portsmouth Hospital NHS Trust* [2005] EWCA Civ 1181 [91].

⁷⁵ [45].

⁷⁶ [46].

⁷⁷ *W v M* (op cit, n 1), [249]

⁷⁸ [49].

⁷⁹ [70].

⁸⁰ Note also that, in contrast to N's case, Baker J heard evidence not only from M's family and the expert medical witnesses, but also 10 members of the team caring for M in the nursing home.

⁸¹ [46].

⁸² [28].

⁸³ [30]. See also *Wye Valley NHS Trust v B* [2015] EWCOP 60.

⁸⁴ [32].

⁸⁵ [59] Like some earlier judgments, Hayden J's decision might therefore owe something to narrative ethics: see R Huxtable, 'Re B (Consent to Treatment: Capacity): A right to die or is it right to die?' (2002) 14(3) *Child and Family Law Quarterly* 341.

⁸⁶ [3]. For example, the references to N's poor cooking skills [58] and difficulties with a paternity suit [59].

⁸⁷ E.g. [71], [74], [75].

⁸⁸ J Coggon, 'Varied and principled understandings of autonomy in English law: Justifiable inconsistency or blinkered moralism?' (2007) 15 *Health Care Anal* 235.

objective good;⁸⁹ Hayden J, meanwhile, appears to treat them as synonymous.⁹⁰ Of course, dignity is a notoriously contested concept.⁹¹ Further work is needed on how the judges do – and should – deploy such values when assessing an incapacitated patient’s best interests.⁹² Dignity’s complexities aside, however, respect for autonomy appears to be the dominant strain in Hayden J’s decision. Might this herald a new dawn for MCS decisions?

C. False Dawn?

Autonomy might continue to be in the ascendancy in some areas of healthcare law,⁹³ and would appear to be here, but healthcare law is no stranger to false dawns.⁹⁴ There are four features of this case which could dampen the reception anticipated from autonomy’s enthusiasts, and which also help to explain why M and N had such different fates.

First, it cannot have harmed the case for withdrawing CANH from N that the declaration sought was unopposed. The Official Solicitor ultimately sided with the family’s views, prompting Hedley J (appropriately) to seek further evidence.⁹⁵ Opinions appeared more divided in M’s case. Perhaps, then, the degree of consensus in N’s situation exerted some influence over the final decision.

Secondly, despite the dominance of autonomy in his decision, N’s wishes were not the only factors for which Hayden J had regard. Note how he also cited ‘the intrusive nature of the treatment and its minimal potential to achieve any medical objective’,⁹⁶ noting that little could be done to improve N’s quality of life, alongside the fact that her life expectancy was ‘in the region of three to five years’.⁹⁷ As such, the judge was mindful of other conceptions of best interests, since he judged there to be little chance of improving N’s quality of life (and thus her mental state) or significantly extending her life (and thus promoting an objective good). Contrast N’s situation with M’s, who was thought to have a life expectancy of 10 years, and for whom the court felt there were options available for enhancing her quality of life.⁹⁸

Thirdly, even the injection of autonomy might not be all that it appeared. On occasion, the bar that must be cleared before a wish counts as autonomous and is honoured has been set rather low: the judges have suggested, for example, that a competent adult can refuse treatment ‘for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death’.⁹⁹ This seems expressive of what Coggon dubs ‘current desire autonomy’.¹⁰⁰ N’s case suggests the bar might be rather higher, and more expressive of an individual’s ‘best’ desires. Perhaps not just ‘any reason’ will make the grade: what is needed is a well-evidenced, durable and consistent package of wishes and values.

The evidence from N’s family, with whom Hayden J was evidently impressed, appeared uniform and voluminous. Despite offering similar accounts of what she would want, M’s

⁸⁹ [67].

⁹⁰ [79].

⁹¹ E.g. C Foster, *Human Dignity in Bioethics and Law* (Hart, Oxford 2011).

⁹² The author is beginning such research in ‘Best Interests in Medical Ethics and Law (BABEL)’, a project funded by the Wellcome Trust.

⁹³ E.g. *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

⁹⁴ M Davies, ‘The “New Bolam”: Another false dawn for medical negligence?’ (1996) 12(4) *PN* 120.

⁹⁵ [62]–[64].

⁹⁶ [75] Keown might object that the CANH is achieving an objective, in feeding and hydrating N. Hayden J here appears to be oriented towards what Keown would dub N’s ‘Quality of life’, rather than promoting the sanctity of life. See, generally, Keown (op cit, n 59).

⁹⁷ [33].

⁹⁸ *W v M* (op cit, n 1), [26].

⁹⁹ *In re MB (Medical Treatment)* [1997] 2 FLR 426, 432.

¹⁰⁰ Coggon (op cit, n 87).

family appeared to have less such evidence to offer.¹⁰¹ Notice also that N had long endured multiple sclerosis, and presumably knew what her future held. M, meanwhile, entered a MCS after contracting viral encephalitis. N was also long resistant to her plight, wishing to die. Time seems to play a role for Hayden J: ‘This was now nearly twenty years ago’, he says, noting when she first started to express such thoughts.¹⁰² Her reactions appeared to be consistent, and also aligned with her independent character. Healthcare law has encountered such individuals before: Ms B, who persistently refused the provision of artificial ventilation over many months, had her wish granted.¹⁰³ Although they do not (or cannot) say so outright, perhaps the judges require compelling evidence of the durability and consistency of the patient’s wishes before the sanctity of life will be ousted.

Finally, a darker reading might be possible. N’s case was decided days before MacDonald J confirmed that C, a 50-year-old woman, had the capacity to refuse life-saving dialysis.¹⁰⁴ C’s life had ‘always revolved around her looks, men, and material possessions’;¹⁰⁵ amongst her reasons for refusing treatment were the loss of ‘her former “sparkly” lifestyle’ and ‘her desire not to get old and lose her appearance’.¹⁰⁶ Recall that N ‘could at times be capricious, selfish and seemingly shallow’.¹⁰⁷ Whilst they evidently differ, N and C both appear to have been strong-willed and independent, but also ‘shallow’ and somewhat ‘difficult’ individuals. Might such characteristics incline the court away from enforced treatment?

We should not make too much of their temporal coincidence and any (superficial) similarities between the two patients.¹⁰⁸ What we should note, however, is that the situation in N’s case has features which suggest that Hayden J’s ruling is not an unqualified victory for patient autonomy.

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¹⁰¹ Maybe understandably so, given the abruptness of M’s decline. I have commented elsewhere on the clairvoyance the law seems to require of such a patient: R Huxtable, ‘Treating the Minimally Conscious Patient: Life Before Choice?’ (2012) 9 *Journal of Bioethical Inquiry* 9; Huxtable (op cit, n 6).

¹⁰² [57].

¹⁰³ *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam); Huxtable (op cit, n 85). Of course, *Pretty* (op cit, n 40) demonstrates that not every independent, consistent wish will be granted. Still, cases like B’s and N’s might indicate that such a wish will be granted, if what is requested is lawfully available (as opposed to assisted suicide, as sought in *Pretty*, which is not).

¹⁰⁴ *Kings College Hospital NHS Foundation Trust v C* [2015] EWCOP 80.

¹⁰⁵ Ibid [63].

¹⁰⁶ Ibid [69].

¹⁰⁷ [50].

¹⁰⁸ Indeed, not every ‘difficult’ patient has their desire to die granted: *R v Collins and another, ex parte Brady* (2000) 58 BMLR 173.